Report
Of the
Governor's Health Care Listening Sessions

Office of the Governor
Office of the Commissioner of Insurance
Department of Health and Family Services
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Introduction

On June 4, 2002, Governor Scott McCallum anounced that he was sponsoring a series of health care listening sessions. Escalating health care costs and problems with health care accessibility have become the core problem facing Wisconsin's employers and families.

"Employees are seeing their wages stunted and employers are struggling to maintain their bottom line. Meanwhile, some residents have difficulty getting the health care services they need. Wisconsin has long been known as a laboratory for change. It's time to gather our best ideas and act on them" said Governor McCallum.

Governor McCallum, Connie O'Connell, Commissioner of Insurance, and, Phyllis Dubé, Secretary of the Department of Health and Family Services, lead the sessions in six locations around the state including Milwaukee, Green Bay, Wausau, Superior, La Crosse, and Eau Claire. The goal of the sessions was to determine the best practices used by employers in the continued delivery of health care benefits to their employees.

This report is a summary of the testimony that was heard at listening sessions. Overall themes were clearly determinable at each session and they included; employee wellness, Medicare reimbursements, health care purchasing; workforce shortages; health care data; and innovation and collaboration. This report follows those themes in its organization. The combination of improving lifestyles through promotion of wellness, improving quality of care and making effective yet cost conscious choices in purchasing health care provide opportunities to address overall health care costs.

Impact of Lifestyle Choices

"We are experiencing some worrisome disease trends. Those two disease trends are…the problem of overweight status and obesity and also the epidemic of diabetes that flow from that. The important thing is that these diseases are in large measure preventable and also represent as much as twenty-five percent of our health care costs." William L. Washington, MD, MHA, Wausau, August 28, 2002

"By providing opportunities for employees to improve their physical well being, employers will see increased productivity and reduced health expenditures. That translates into lower health insurance premiums."- Governor Scott McCallum, Milwaukee, June 24, 2002

Numerous speakers at the listening sessions highlighted the impact of lifestyle choices including high fat diets and low exercise that typify Modern lifestyle. Speakers pointed out that this development corresponds with trends in how food is package and sold as well as the type of recreation we participate in. Speakers also discussed how this problem could be addressed.

How has our lifestyle changed over the last 20 years?

Dr. William Washington of the Marshfield Clinic highlighted the trends emphasizing the growth of video games, Internet, television and the use of powered transportation. He also indicated there has been a decrease in aerobic activity in physical education. At the same time, the number of large-size portions offered by fast food restaurants has grown. Prior to 1979, few large-size portions were offered. However, starting in 1980 more than 20 larger portions were offered and by the time period of 1995-99 approximately 65 super-size portions were available. (Young LR, Nestle M. Am J Public Health 2002;92:246-249.). These increased portions combined with the wrong mix of foods are taking a heavy toll.

How has our health status changed over the last 20 years?

Obesity is generally defined as a body mass index (BMI) of 30 or more. In approximately the last 20 years, the obese fraction of our population has almost doubled. The more frightening statistic is that during this time period obesity among adolescents has almost tripled. Childhood obesity predicts adult obesity. Therefore, the data regarding children is an indicator or our future. If we do not make a change, we will have an even less healthy more costly population in the years to come.

How does obesity impact our health? Heart disease and diabetes are the most costly downstream effects of obesity. However, a correlation with other diseases such as colon cancer is indicated.

Complications from Type II Diabetes include amputations, kidney failure, stroke, blindness and heart disease.

Impact on health care costs

Numerous studies have offered quantifiable data showing a link between higher health care costs and obesity. The Kaiser Foundation conducted a study in Oakland, California the found individuals with a BMI of 30-30.49 had increased claims costs of 25% and that a BMI of more than 35% increased claims 44%. The Medstat Group Study found BMI of more than 27.5% cost 25% more than the ideal body weight.

John Smylie of Security Health Plan used a more conservative estimate of 20% of our health insurance premiums are directly related to inactivity and overnutrition. He pointed out that this amount approaches $200 per month per family. To put this in context, he said for many rural counties, $200 is the equivalent of 25% of the average monthly household income.

Benjamin Cutler of Fortis Health provided data about the 1,700 employees they insure in the Milwaukee area. Ten percent of these customers make up ninety percent of their costs. He further indicated that seventy percent of the spending is for preventable disease.

Measures to address

Individual responsibility

The good news is that each individual can take steps to address this problem. Dr. Washington offered data that showed as little as a 7% weight loss through diet and exercise in patients at risk will reduce the progression to Diabetes at four years by 58%. Nationwide, our health care system would save $2.244 billion per year in Diabetes care alone from this reduction. (Tuomilehto in NEJM 344:1243-1350, 2001 & U.S. Diabetes Prevention Program Research Group in NEJM 346:393-403, 2002.

Governor McCallum used the listening sessions as an opportunity to advocate for this personal responsibility. He advocated that individuals add 30 minutes of physical activity per day and reducing calorie consumption by 100. He pointed out that these changes will result in a reduction of 20 pounds in one year for the average person.

Employer actions

Governor McCallum led by example by launching the Wisconsin Encourages Healthy Lifestyles (WEHL) Initiative. By executive order, the Governor created the WEHL Council to promote healthy lifestyles across all state agencies. The Governor acknowledged that by providing opportunities for employees to improve their physical well being, employers will see increased productivity and reduced health expenditures.

The Governor also acknowledged that many Wisconsin Employers have long been active in this effort. The listening sessions provided an opportunity to highlight these employer-based wellness initiatives.

Deb Seyler of the Wellness Council of Wisconsin defined wellness in the following manner:

- The process of being aware of and actively working toward better health
- Includes multiple dimensions: physical, mental, and emotional health
- The terms wellness and health promotion are used interchangeably.

Wellness programs address issues as varied as physical activity and nutrition to seat belts and disease management.

Ms. Seyler also gave the following six reasons why employers should consider implementing a wellness program:

1. Our citizens are not the healthiest.
2. Much illness is preventable.
3. Healthcare costs are causing concern.
4. The worksite is an ideal setting (Americans spend most of their waking hours at the worksite. Employers have a vested interest in health-related issues.
5. The research supports the effectiveness of worksite health promotion.
6. More and more companies are doing it. More than 81% of American employers with 50 or more employees have some form of health promotion.

Wisconsin employers provided information at the sessions about successful wellness programs. For example, the Wellness Councils of America have held up several Wisconsin employers for their effective programs. Fortis Health of Milwaukee was given the Silver Well Workplace award. Their program includes a walking club, ergonomic program and annual wellness week. The company cites paybacks of 5:1 to 6:1 on dollars spent on employee health promotion. Highsmith Inc. of Fort Atkinson received the Platinum award for their initiative called TAG: Total commitment to developing human potential, Access to learning opportunities and Growth as an individual and as a company. Lab Safety Supply of Janesville received both the Platinum and Gold awards. They offer their employees on-site fitness center, convenient care medical clinic and special classes and programs.

Thrivent Financial for Lutherans (formerly Aid Association for Lutherans and Lutheran Brotherhood) received the Gold Award in 1996 and 1999. They credit the success of their program with the top-down endorsement and congruence with the mission of the company. The program focuses on prevention, primary health care and employee assistance program. They conduct health risk appraisals on staff considering factors such as overweight, smoking, seat belt use, etc. Providing on-site access to primary care has been a value to the company and employees by decreasing time away from work, providing convenient access to health care, improving self-care skills through education and resulting in healthier employees.

The Green Bay Chamber of Commerce has responded to this trend with the Bay Area Community Health Partnership. The goal of this partnership is to bring together and design a wellness program to improve the health of employees and thereby seek to control their health insurance costs through better utilization of services. This fall the Chamber sponsored a one day Wellness symposium allowing employers to share their best practices.

Community-wide solutions

Some communities have determined that while individuals and employers can have a positive impact on improving wellness that the greatest impact is felt when the community works together. Wausau and Marshfield are engaged in community-wide efforts.

Dr. Sharon Fox of the Wausau Health Foundation stressed the importance of conducting a community-wide assessment, prioritizing needs and monitoring change.

Dr. William Washington of the Marshfield Clinic discussed their Healthy Lifestyles Coalition. The Marshfield Clinic provided funding to start the Coalition based on the belief that efforts to combat the growing incidence of obesity must be community-wide and self-sustaining. The Coalition is comprised of individuals representing schools, medical, social service, government, public health and other organizations. When the coalition held its first annual symposium, 125 individuals showed up. At that time, the group developed a core message: promote energy balance, portion size, food group choices and 30 minutes of activity.

The common sense approach by the coalition is already having an impact on the community. The school district has embraced the effort redesigning health and physical education curriculum, redesigning food service menus, vending contracts, and extra-curricular food events. The strong hope is that if children embrace a healthy lifestyle, they may encourage their parents to do so as well.

The coalition is identifying changes employers can make as well. For example creating routes within building to encourage walking on breaks and putting up signs by elevators to encourage the use of stairs. There is a role for city officials such as designing bike or pedestrian baths to link up parks.

Although the original effort is focused on the Marshfield community, the coalition has a broader vision. They hope to measure the results of the program and offer a model that can be used elsewhere. This public/private partnership is one of the most exciting wellness efforts in the state.

Medicare Reimbursement Inequities

> ***"With each passing year, the gap between the cost of providing healthcare services and the amount we receive in reimbursement continues to widen."***- Glenn Forbes, M.D , President and CEO; and Ron Paczkowski, Executive Vice President, Franciscan Skemp Healthcare- September 23, 2002, La Crosse, WI

Information about Medicare reimbursement inequities were discussed at almost every listening session. While commonly known throughout the health care industry, the dire position that Medicare puts Wisconsin in is largely unknown throughout the rest of the State of Wisconsin.

The Medicare reimbursement formula was originally created in the late 1960s, when health care costs in Wisconsin, compared to other states, relatively inexpensive. This is not the case in the year 2002, however. Wisconsin's health care costs are some of the highest in the nation on a per capita basis. Yet the formula still treats Wisconsin as it did 35 years ago. As a result, health care providers are not receiving full reimbursement for up to $1 billion in services when compared to the average reimbursement levels. Health care providers then turn look to recoup these costs to those that can pay, specifically commercial payers such as insurers and self funded companies. Referred to as "cost shifting", a number of speakers at the listening sessions identified this as the #1 factor responsible to rising health care costs. This was evidenced by a 2001 study by Milliman USA, who found that compared to states with higher Medicare reimbursements, Wisconsin commercial health insurance costs were 20% higher than Florida, 31% higher than Louisiana, and 44% higher than California.

Characterized as an unfair tax on Wisconsin citizens, the reimbursement formula affects both hospitals and physicians.

Wisconsin hospitals are paid 11% less than their costs from Medicare and Wisconsin ranks 45th nationally in the percent of costs paid for providing service to Medicare beneficiaries. Factors that cause this shortfall include the Base Payment Rate, which gives large metropolitan areas (with populations over 1 million) a 1.6% higher base rate than other areas. This additional rate is not related to current costs but does discriminate against hospitals based on geographic location.

Another factor is the Medicare Wage Index. This index applies a wage index percentage against Medicare Costs. This index is applied to 71% of Medicare costs. In Wisconsin, where wages comprise 55% of total costs, it is easy to see that the wage index is applied to a vastly greater share of costs than just labor only. And since Wisconsin's wage index itself is low, compared to states like

New York or California, payments to hospitals are even lower than they should be.

> ***"The "bottom line" for St. Mary' Hospital in Superior is that 4 out of 5 patients who seek service at our facility are covered by programs that pay less than cost. It is too much to ask every fifth patient to carry the load for the other four."*** -Terry R. Jacobson , CEO, St. Mary's Hospital of Superior

The conditions faced by providers in northern Wisconsin provide an insight to the future of Medicare in its current form. According to the Center for Medicare and Medicaid Services (CMS) by the year 2020, the ratio of workers paying into the Medicare system to beneficiaries will fall to 2.8 workers per beneficiaries. By 2040, this ratio will fall to 2.2 workers per beneficiary. CMS calls this a crisis point. In 1999, 21 northern Wisconsin Counties had fallen below 3 workers per beneficiary and 3 Wisconsin counties are below 2 workers per beneficiaries. The crisis already exists in Wisconsin.

For northern Wisconsin and rural providers, the majority of their patients are Medicare patients. They are being asked to essentially lose money on every patient they see. For them there is no other choice but to shift those costs over to private payers and fuel the health insurance increases.

The solution universally proposed by all speakers to the listening sessions was for Wisconsin to press the issue with its congressional delegation and the Bush Administration to provide for equitable distribution of Medicare funds.

Health Care Purchasing

Consumerism and Product Design

> ***"I have health insurance, therefore, I am entitled to what I want. Absent a greater degree of personal responsibility, this entitlement demand will continue to outstrip the resource and process capacity of the healthcare system.****-Jim Hartert, Chief Medical Officer, Cobalt Corporation, Milwaukee, June, 24, 2002*
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> ***"People just don't spend other people's money as wisely as they do their own."****-Fred Moore, CEO, Wausau Benefits, Wausau, Wisconsin, August 28, 2002*

A common theme among listening session participants was the need to involve patients more in the health care purchasing decision. Too often, patients do not know the real cost of the treatments they receive. To them, a prescription is a $5 or $10 item. A doctor's office visit is $20 or $25, if there is a charge at all. Those who use the health care system have become insulated from the underlying costs. Not many would be able to identify what the actual cost of some commonly prescribed medications, like Vioxx, Prilosec, or Lipitor, would be or of options for other than these brands. Nor would they be able to cite the cost of a MRI or a colonoscopy.

It is the lack of patient knowledge that is often cited for contributing to the increased and in some party's viewpoints the unnecessary utilization of the health care system. Often, the better the health care plan, or the more the insurance company pays for and the less that the insured has to pay for, the higher the rate of utilization of the system. As the participants commented, once insureds are made to make more of a commitment to their own well being, more "skin in the game" as some refer to it, their utilization habits will change as well as better commitment to a healthier lifestyle.

There were a number of suggestions that were thought to bring a consumer focus back into health care purchasing. Largely centered on the elimination of first dollar coverage in health insurance policies and deeper involvement in the overall cost through participation in decision making for procedures and medications, the core theme was to eliminate unnecessary treatments by requiring patients to participate financially in their ordinary health care needs. Insurance would still be a focal part of the health benefit, but it would be more focused on the catastrophic expenses that occur rather than the office visits and the prescriptions.

The forms taken were varied:

- ***Medical Savings Accounts*** where the employer purchases a large deductible health plan for employees and places a fixed dollar amount in an account for employees to use for ordinary medical expenses to fill the deductible. The employee would be able to place money in the account as well.

- ***Defined Contribution Plans*** which offer a broad continuum of variations involving employers giving the employee a fixed dollar amount to purchase a health care plan of their own.

- ***Standard benefit design.*** Limit the types of health plans available to Wisconsin employers by allowing a standard type of plan design with adjustments in deductibles and co-pays.

Other suggestions on health plan designs included:

- ***Alternative contracting for employers.*** Having employer's contract directly with providers to provide health benefits to employees. A self-funded mechanism that eliminates insurer participation or uses an insurer as a third party administrator. Other employers speaking to the listening session have on-site medical clinics or sponsor health events that perform examinations for such conditions as high blood pressure or high cholesterol.

- ***Eliminating (or equal application of) mandates.*** Health insurance mandates are said to add as much as 15% to the cost of a health insurance policy. Elimination of mandatory coverages and benefits it was suggested could benefit employers, particularly small employers.

- ***Incentives for Wellness Programs and Preventative Care.*** With much of the cost of medical care being attributable to preventable illness, (as much as 70% to 75%) some speakers to the listening sessions addressed the need for employers and insurers to focus on eliminating high costs of health care through active wellness programs or designing health plans to favor preventative care and chronic disease management.

- ***Drug Formularies and Direct to Consumer Advertising.*** Session speakers encouraged insurers to adopt a drug formulary structure, either closed or tiered that steer patients in the direction of lower cost drugs. Similarly, there was discussion of the effect of direct to consumer advertising by drug manufacturers. Limits, or outright prohibitions, were raised as a way of reducing the impact of the demand created by manufacturers for their most expensive products.

Quality of Care

> ***"Hospitals, physicians, pharmacists and others need to do a much better job communicating with each other and working together."****-G. Edwin Howe, President, Aurora Health Care- Milwaukee, June 24, 2002*

Speakers to the listening sessions expressed the need for change in the health care delivery system. They envision a system that is standardized, integrated, patient focused, safe and efficient. Central to the creation of such a system is a standardized means of measuring quality in health care delivery.

One group often mentioned was the Leapfrog Group. The Leapfrog Group is a consortium of 120 Fortune 500 companies and other organizations. Their focus is on patient safety and the members have agreed to focus their purchasing decisions based on stringent safety measures. Leapfrog Group members provide health benefits to 33 million employees and dependents spending $56 million annually.

The Leapfrog Group has been a national leader in identifying the dimensions of health care quality issues. Included are specific identification of common health services documented to be overused and proven effective interventions that are underused.

Leapfrog has developed three quantifiable measures of patient safety. Computer Physician Order Entry (CPOE) would automate the prescription process to reduce errors. Evidence-Based Hospital Referral (EHR) would measure high-risk and elective measures would help guide providers to facilities with superior outcomes. And ICU Physician Staffing (ICU) would measure ICU-only staffing and management levels. The Leapfrog Group believes that ICUs managed and staffed and monitored by full time intensivists will reduce the risk of death in emergency situations.

The Institute of Medicine has reported that $9-15 billion annually is spent to treat injuries from preventable errors. The Midwest Business Group on Health and The Juran Institute estimates one-third of health insurance premium costs are wasted on poor quality.

Health Care Workforce Shortage Requires Comprehensive Collaborative Approach

"Addressing the health care worker shortage is not a one-time effort. To adequately address the shortage, there must be a continued, ongoing effort to both coordinate and oversee the efforts to ensure a high-quality workforce delivering health care that is second to none." *Report by the Governor's Health Care Worker Shortage Committee*

Wisconsin's current healthcare workforce shortage reflects a national problem and certainly is a contributing health care cost driver in the state. Twenty-seven states enacted legislation in 2001 to address workforce shortage issues through a variety of mechanisms including scholarship and loan forgiveness programs, according to the National Council of State Legislatures. The workforce shortages result in higher costs as facilities are forced to pay staff overtime and raise salaries to attract new candidates from the shrinking job pool. Demographic trends heighten the problem, as our aging population will need more intensive health care services.

Department of Health and Family Services (DHFS) nursing survey estimated that 9,500 nurses plan to leave the profession or reduce hours during the next year alone. A 2000 Hospital Personnel Survey conducted jointly by DHFS and the Wisconsin Health and Hospital Association found nursing jobs to be the highest area of job vacancies. Nursing homes are experiencing a high turnover in skilled nursing staff and reported vacancies of 15 percent in 2000.

Reasons vary for why health care facilities are finding it difficult to retain qualified workers. Factors include work schedules that are not family friendly, wage and benefits, and stress related to the job. Many care providers become frustrated with administrative requirements due to reimbursement system, government regulation and legal liability concerns. In today's health care system patients in a hospital are likely sicker and in for shorter stays and these administrative tasks mean less time for direct care of patients.

A recently completed report by the Governor's Health Care Worker Shortage Committee provided for goals and action steps in the following areas:

- Increasing the number and diversity of individuals choosing health care occupations and expand educational capacity to meet the needs of the labor force.

- Increasing the retention rates of Wisconsin's current health care workforce.

- Redesigning the health care system and becoming proactive in prevention and wellness promotion to improve both health work and population outcomes.

Throughout the listening sessions encouraging reports were heard from the University of Wisconsin System and Technical College System on stepped-up efforts in education and partnerships with private sector health care providers on addressing the worker shortage. The recommended action plans from the Governor's Health Care Worker Shortage Committee must be implemented.

Workforce Profile:

Chippewa Valley Technical College (CVTC) Health Education Center

The University of Wisconsin System and State Technical College System is stepping forward to address health care workforce shortage issues. One of the more innovative programs for promoting public and private partnerships and securing a variety of funding sources is the Chippewa Valley Technical College Health Education Center. The two-phased project will provide a modern facility and state-of-the-art equipment necessary to deliver quality health care education to over 750 students and 2,000 current health care workers. The CVTC will partner with Luther Hospital, Sacred Heart Hospital, Marshfield Clinic, Midelfort Clinic, UW-Madison Eau Claire Family Clinic, UW-Eau Claire, K-12 schools and others. What is being developed is a regional health care training center including a human patient simulation lab, modernized multi-media training facilities and incorporating the UW-Madison Eau Claire Family Medicine Clinic with the CVTC Dental Hygiene Clinic. This onsite-practicing clinic will enhance educational experiences for students. Further, these education and training facilities will benefit the region by providing low cost health care services to lower income and disadvantaged patients. CVTC utilizing a Focus Learning Center Model developed a rapid response plan to meet the health care workforce of the Chippewa Valley and region.

For more information contact: Bill Ihlenfeldt, President of Chippewa Valley Technical College

Health Care Data Can Boost Consumer Awareness

"The missing link is the involvement of the consumer in the health care system. By giving consumers a vested interest and responsibility, along with the full disclosure of true and complete data by the health care industry, consumers and businesses can shop on their own or in collaboration with their health care professionals, armed with knowledge and full information. The consumer involvement will help to moderate the one-sided control of the current system. All parties must participate to let the market place function for mutual benefit. It's a good check and balance, returning some controls to an out of balance system." *Jim Kurtz, business person*

Many health care consumers are unaware of the specific costs of the health care services they utilize every year. This is due in large part to what is the called the "third-party" payment system of insurance companies paying for health care services of our insured population. Several speakers at the Governor's Health Care Cost Listening Session discussed the need for improved consumer knowledge and participation in the health care market. One critical component to improving consumer knowledge of health care costs is access to data for baseline comparisons.

Data on hospital charges has been collected in Wisconsin since 1988 as a part of legislation stemming from 1987 Wisconsin Act 399. Wisconsin state law, Section 153.05 (1), places the following requirement on the Department: "In order to provide to hospitals, health care providers, insurers, consumers, governmental agencies and others information concerning health care providers and uncompensated health care services, and in order to provide information to assist in peer review for the purpose of quality assurance, the department shall collect, analyze, and disseminate health care information, as adjusted for case mix and severity, in language that is understandable to lay persons."

The Department is responsible for producing health care information that purchasers, policy makers, providers, and consumers can use to make knowledgeable health care decisions, with the intention that such decisions will improve the operation of Wisconsin's health care system and the health status of Wisconsin's citizens. The Department was not designated to take further action if the free competition model didn't contain costs as effectively as its proponents had predicted. Reports issued annually are publicly available and data sets are available for purchasing. The reports include:

- ***Hospital Rate Increase Report***: Hospitals must publish notarized notices about their rate increases in newspapers and submit this data to BHI. BHI prepares a report listing the rate increases for all hospitals in the state. The report identifies hospitals by name and location, the effective date of their

increase, and the annualized percentage increase. The report can be used to understand changes in hospital rates, to compare rates across hospitals and to project expected costs of hospitalizations.

- ***Uncompensated Health Care Services Report:*** Hospitals must annually submit fiscal surveys and plans for the provision of uncompensated health care to BHI. Based on this information, BHI prepares a report which presents the following individual hospital information:

    - total dollar amounts of charity care/bad debt
    - proportion of total gross patient revenue represented by charity care/bad debt
    - proportion of non-governmental patient revenue represented by charity care/bad debt,
    - current and projected number of patients who received charity care/had bad debt accounts, and
    - extent to which hospitals had outstanding obligations on state loan funds.

    For hospitals with county general relief revenues that exceed $500,000 or 1% of total gross patient revenue, the report lists the amount of general relief revenues received, the proportion of total gross revenue represented by general relief, and the proportion of charges for general relief that were reimbursed by counties.

    The report presents summary statistics on uncompensated health care services and lists hospital with obligations to provide reasonable amounts of charity care. It discusses the definition of uncompensated health care services; problems associated with measuring hospitals charitable contributions; and how hospitals project uncompensated health care, verify the need for charity care, and notify the public about charity care.

    The report can be used to determine the level of uncompensated health care provided throughout the state, whether the burden is fairly shared by all hospitals, the extent to which uncompensated care affects hospital charges and hospitals' ability to provide community service.

- ***Guide to Wisconsin Hospitals:*** Based on annual fiscal and utilization/staffing surveys, this report presents descriptive financial, utilization and staffing information about individual hospitals and summary and trend information for selected items. The fiscal data presented in the report include information on each hospital's revenue and expenses, revenue per patient stay, profit margins, and balance sheet information on assets and liabilities. Comparative information by type of hospital, geographic area and patient volume is also presented. Because the data are provided via self-reporting

survey tools (e.g., financial data are not verified by audited financial statements), data limitations and caveats are presented.

The report can be used as a tool to evaluate the fiscal health and operating efficiency of hospitals, to evaluate levels of reimbursement and to determine service availability patterns.

- ***Annual Health Care Data Report:*** The report contains information on services provided to hospital inpatients, including diagnoses, procedures performed, length of stay, expected pay source, discharge status and charges for services. It presents the difference between patient retail and discounted charges, adjusts charge data by patient severity and explains the data adjustment methodology. Statewide data on the most frequently occurring diagnoses, diagnoses with the most expensive charges, and diagnoses with the highest total charges are also reported. Information is presented for individual hospitals, with comparisons to previous year's data. The report also contains similar information on ambulatory surgeries.

  This data has been available online for computer users, but has historically been presented in rather detailed table formats that may not be consumer friendly to a general audience. After the first two sessions of the Health Care Cost Listening session Governor Scott McCallum directed DHFS to develop a demonstrate project for the purpose of testing a redesign of the hospital health care charge data to measure whether a more consumer friendly format could be achieved. The new demonstration site went live in September of 2002 and is being evaluated for a permanent change.

Innovation and Collaboration Needed in Health Care Delivery

Both publicly and privately funded health care provider organizations are utilizing disease management strategies and collaborative models to improve patient care. Disease Management is a system of coordinated healthcare interventions for populations with conditions that require significant patient self-care efforts. Disease management assumes that for the target population:

1) Variance exists in medical practices;
2) This variance results in different health outcomes; and
3) It is possible to develop a health-care system that improves outcomes, such as a decrease in costs or improved quality of care.

Major components of Disease Management include:

- Identification of target populations. Typical populations include individuals with diabetes, asthma, HIV/AIDS, heart disease, Hepatitis C, and mental illness.
- Establishment of evidence-based practice guidelines, including collaborative practice models with physician and support-service providers
- Patient self-management education including primary prevention, behavior modification programs, and compliance and surveillance.
- Process and outcomes measurement, evaluation, and management
- Periodic reporting including feedback, which may include communication with patient, physician, health plan and ancillary providers, and practice profiling.

Wisconsin Medicaid's Current Programs and Activities

Wisconsin Medicaid uses a coordinated approach to disease management, both for persons receiving services through fee-for-service and through managed care. Medicaid administers targeted disease management programs that produce outcomes expected to improve the health status of recipients and result in cost savings. Medicaid initiatives providing disease management, including management of medications, include:

Targeted Disease-Specific Interventions. Wisconsin Medicaid targets interventions for patients with specific diseases in a comprehensive and coordinated manner by working directly with local providers. These targeted interventions include:

- ***Asthma.*** The Wisconsin Medicaid Drug Utilization Review (DUR) Program identifies recipients who have frequent hospital use for asthmatic complications and do not receive appropriate drug therapy. Prescribers and

pharmacists are alerted to their patient's drug use problems and potential therapeutic responses.

- ***Diabetes.*** The Diabetes Advisory Group, a partnership of the state, health insurers, providers, purchasers, professional organizations and academia, has developed guidelines for diabetic care in an effort to provide standards for basic preventive services. Most HMOs in the state readily adopted these standards and are working on measures of diabetes care including eye exams, glucose tests, lipid management, kidney function and special immunizations.

- ***Blood Lead Testing.*** DHFS identifies children who have not had the required blood-lead tests billed to Medicaid and notifies the managed care organization or the fee-for-service outreach agency for follow-up and action.

- ***Tobacco Cessation***. The Wisconsin Medicaid Program has entered into a number of partnerships designed to systematically address tobacco use by Medicaid recipients. In addition, a partnership with the Wisconsin Women's Health Foundation and the Bureau of Family and Community Health Program within the Division of Public Health has resulted in a pilot project to address tobacco use by low income, pregnant women.

Many speakers at the Health Care cost listening sessions provide outlines of their disease management and collaborative strategies. While each health care organization may have unique characteristics allowing for some strategies to work better within their facilities, there are some general ideas and guidelines that need to be shared. It is recommended that a private and public health care summit meeting be held to exchange ideas on best practices for disease management and provider collaboration.

State Health Plan-A Guide Post for Health Care Priorities

The Department of Health and Family Services is required to develop a state health plan every ten years. The Wisconsin Turning Point Transformation Team, a group of more than 40 individuals representing all segments of public health, created the plan which fulfills the statutory requirement as well as provides the framework for the transformation of Wisconsin's public health system. Hundreds of citizens assisted in preparing this plan that was released in 2002.

The transformation framework of "healthy people in healthy Wisconsin communities" will guide public health system partners to do business differently. This includes data-guided decision making, strategic planning, quality improvement, and building sustainable collaborative partnerships at the state and local levels throughout Wisconsin. This will enable the partners to achieve the two critical outcomes of 1) improved health of the public, and 2) improved capacity of the public health system.

The Healthiest Wisconsin 2010 implementation plan details the steps the public health system partners will take over the next 10 years to address over 60 long-term outcome objectives. The creation of Healthiest Wisconsin 2010 and the responsibility to see that the plan is implemented has been, and will continue to be the shared responsibility of all of Wisconsin's public health partners. These partners include state and local governments, the public, private, nonprofit, and voluntary sectors throughout Wisconsin.

Health Priorities outlined in the plan are:

- Adequate and Appropriate Nutrition
- Alcohol and other Substance Use and Addiction
- Environmental and Occupational Health Hazards
- Existing, Emerging, and Re-Emerging Communicable Diseases
- High Risk Sexual Behavior
- Intentional and Unintentional Injuries and Violence
- Mental Health and Mental Disorders
- Overweight, Obesity, Lack of Physical Activity
- Social and Economic Factors that Influence Health
- Tobacco Use and Exposure

System Priorities outlined in the plan are:

- Integrated electronic data and information systems
- Community health improvement processes and plans
- Coordination of state and local public health system partnerships
- Sufficient, competent workforce
- Equitable, adequate, and stable financing

The State Health Plan may be found on the internet at www.dhfs.state.wi.us/Health/StateHealthPlan/